U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 30 December 2003

CASE NO. 2002-BLA-5066

In the Matter of:

JOHN W. CUTRIGHT,
Claimant

v.

SEWELL COAL COMPANY,
Employer

and

DIRECTOR, OFFICE OF WORKERS COMPENSATION PROGRAMS,
Party-in-Interest

APPEARANCES:

Jennifer McGinley, Esquire
For the Claimant

Mary Rich Maloy, Esquire
For the Employer

Before: RICHARD A. MORGAN
Administrative Law Judge

DECISION AND ORDER-DENYING BENEFITS

This proceeding arises from a claim for benefits filed by John W. Cutright, a former coal miner, under the Black Lung Benefits Act, 30 U.S.C. §901, et seq. Regulations implementing the Act have been published by the Secretary of Labor in Title 20 of the Code of Federal Regulations.[1]

[1] The Secretary of Labor adopted amendments to the "Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969" as set forth in Federal Register/Vol. 65, No. 245 Wednesday, December 20, 2000. The revised Part 718 regulations became effective on January 19, 2001. Since the current claim was filed on January 25, 2001 (DX 1), the new applications are applicable.

Black lung benefits are awarded to coal miners who are totally disabled by pneumoconiosis caused by inhalation of harmful dust in the course of coal mine employment and to the surviving dependents of coal miners whose death was caused by pneumoconiosis. Coal workers' pneumoconiosis is commonly known as black lung disease.

A formal hearing was held before the undersigned on June 11, 2003, in Beckley, West Virginia. At that time, all parties were afforded full opportunity present evidence and argument as provided in the Act and the regulations issued. Furthermore, the record was held open until July 31, 2003 for the submission of briefs (TR 34). Under "Fax Cover Sheet," dated July 30, 2002, Claimant's counsel requested an extension to file the closing brief, and advised the undersigned that Employer's counsel did not object thereto. Shortly thereafter, Claimant's brief was received on August 7, 2003. The record consists of the hearing transcript, Director's Exhibits 1 through 35 (DX 1-35), and Employer's Exhibits 6 though 10, 15, 17, 18, 19, 23, and 24 (EX 6-10, 15, 17, 18, 19, 23, 24). On the other hand, Employer's Exhibits 1-5, 11-14, 16, 20, 21, and 22 were expressly rejected (TR 33). Furthermore, Employer's Exhibits 25, 26, and 27, which were included in the package of exhibits submitted under a cover sheet entitled "Employer's Index of Exhibits," are also rejected.[2] In addition, I have received and considered the parties' pre-hearing statements and closing arguments.

The findings of fact and conclusions of law which follow are based upon my analysis of the entire record, including all documentary evidence admitted and arguments made. Where pertinent, I have made credibility determinations concerning the evidence.

Procedural History

The Claimant, John W. Cutright, filed applications for Federal black lung benefits on October 21, 1970 (DX 30-1), November 8, 1972 (DX 30-2), October 29, 1991 (DX 31-1), and September 2, 1998 (DX 32-1), which were repeatedly denied (DX 30, 31, 32, 33).[3] The most recent denial of the foregoing claims was issued on August 2, 1999, when the District Director issued a "Proposed Decision and Order Memorandum of Conference," denying benefits (DX 33-41). Claimant did not appeal nor seek modification within one year of the foregoing decision. Accordingly, the above referred claims are deemed finally denied and administratively closed.

On January 25, 2001, Claimant filed the current application for black lung benefits under the Act (DX 1), which was denied by the District Director in a Proposed Decision and Order, dated January 8, 2002 (DX 21). Following Claimant's timely request for a formal hearing (DX 28), this matter was referred to the Office of Administrative Law Judges for adjudication (DX 35). I was assigned the case on January 22, 2003. As previously stated, a formal hearing was held on June 11, 2003, and the record was closed on August 7, 2003, upon receipt of Claimant's brief.

[2] It is unclear whether Employer's Exhibits 25, 26, and 27 were even offered into evidence (TR 30-33).

[3] I note that the District Director's office commingled some of the applications. In particular, those related to the claims filed on October 29, 1991 and September 2, 1998. The applications, evidence, and rulings arising from those applications are mixed within Director's Exhibits 31, 32, and 33 (DX 31, 32, 33).

Issues

The contested issues are as follows:

I. Whether the claim was timely filed?
II. Whether the miner has pneumoconiosis as defined by the Act and the regulations?
III. Whether the miner's pneumoconiosis arose out of coal mine employment?
IV. Whether the miner is totally disabled?
V. Whether the miner's disability is due to pneumoconiosis?
VI. Whether the evidence establishes a material change in conditions per 20 C.F.R. §725.309? [4]

(DX 35, as amended; TR 8-11).

Findings of Fact and Conclusions of Law

I. Background

A. Coal Miner and Length of Coal Mine Employment

The parties stipulated, and I find, that Claimant engaged in coal mine employment for at least 28 years (TR 10-11). On his current application for benefits, Claimant alleged 31 years of coal mine employment (DX 1). Any discrepancy between 28 and 31 years of coal mine employment is inconsequential for the purpose of rendering a decision herein.

B. Timeliness of Filing

Claimant filed his current claim for benefits under the Act on January 25, 2001 (DX 1). There is a rebuttable presumption that every claim for benefits is timely filed. 20 C.F.R. §725.308(c). Employer has failed to present adequate evidence to rebut this presumption, since Claimant was unsure whether Dr. Rasmussen had communicated a finding of total disability due to pneumoconiosis during his initial evaluation, in 1991 (TR 27). Furthermore, I note that this claim is an "additional" or "subsequent" claim under §725.309.

C. Dependents

Claimant has one dependent for the purpose of possible augmentation for benefits under the Act; namely, his spouse, Edna (nee Lilly). (DX 1, 9; TR 24).

D. Personal, Employment, and Smoking History

Claimant was born on May 2, 1935. He engaged in various coal mine jobs throughout most of the period beginning in the 1950's and ending on or about November 1, 1985, when the

[4] The "Refiled Claims" issue was initially not marked as contested on the Form CM-1025 transmittal sheet (DX 35). However, on April 19, 2002, Employer's counsel promptly corrected this omission.

mine closed down (DX 1, 2; TR 18-20). Claimant testified that his last usual coal mine job [*i.e.,* at a job in which he worked regularly for at least one year] was as a heavy equipment operator, which primarily entailed operating a shuttle car, miner, and/or bolting machine at the face (TR 15). In addition to operating the machinery, Clamant stated that his job entailed some manual labor, such as lifting and setting timbers and safety posts which weighed up to 100 pounds; and, were between four and twelve feet in height. Claimant testified that "one person couldn't do it [*i.e.,* set the larger timbers]. (TR 15-18).

On the "Description of Coal Mine Work and Other Employment" form, which was submitted on March 2, 2001, Claimant's last coal mine employment was identified simply as "shuttle car operator." (DX 3). The job duties were described as follows:

> The shuttle car, hauls the coal from the continuous miner at the face, to the feeder, which puts the coal on the belt. Then the belt takes the coal outside, to the tipple. Then it is cleaned and put in railroad cars, for shipping.

(DX 3).

When asked to specify the physical activities required in his last usual coal mine job as a shuttle car operator, in terms of sitting, standing, crawling, lifting, and carrying, Claimant declined to do so; however, he set forth the following overall statement:

> You can't describe how long you would sit and stand each night. I would run the equipment then I would rock dust which consisted of carrying 50 lb bags of rock dust. Then we would set timbers. They would weigh between 50 and 100 lbs. We carried the timbers. When we changed entries we had to hang cable.

(DX 3).

Claimant testified that he last worked regularly in the coal mines for Sewell Coal Company, in 1985, when the mines shut down. Based upon Claimant's testimony, Employment History form, the Social Security records, and, Answers to Interrogatories, I find that Claimant also was employed briefly thereafter for a number of other companies, where he worked on equipment; prepared and loaded coal; worked as a shot firer; and, worked at a cleaning plant. However, none of Claimant's post-Sewell employment was with a company which Claimant worked a calendar year. Accordingly, I find that Sewell Coal Company is the properly designated responsible operator (TR 13, 25-27; DX 2, 5; EX 24, Answer to Interrogatory 3).

Claimant stated that he suffers from breathing problems and has difficulty walking, particularly uphill. He uses a ride-on mower. Claimant testified that, when he walks uphill, he not only becomes short of breath, but also his "chest gets sore." In addition, Claimant complained of a productive cough, especially at night (TR 14-15). Claimant did not feel very sick when he worked in the mines; however, since he retired in 1985, his breathing problem became bad. Claimant stated that he filed for State occupational pneumoconiosis benefits, and was awarded 5% the first time; and, an additional 5% a second time (TR 21-23). Notwithstanding Claimant's complaints, he has not been treated regularly for a chest impairment,

only when he has colds. Furthermore, Claimant does not take any medicine for shortness of breath (TR 23). Claimant's usual activities include spending time at his house, going to the camp he owns approximately six miles away, working at the church, and taking care of his own yard (TR 29).

Claimant testified that he was in a serious motor vehicle accident in 1954 or 1955, when he injured his eye, broke some ribs, and, punctured a lung, while driving a car, while in the Marine Corps. After being hospitalized for 11 months, Claimant was discharged from the Marine Corps. Subsequently, he went to work in the mines, in 1957 (TR 18-20). Claimant's other medical problems include high blood pressure, arthritis, and prostate cancer. However, he does not take any medication for his arthritis; and, Claimant's high blood pressure and prostate cancer are under control (TR 28). Claimant testified that he has never smoked (TR 27-28).

II. New Medical Evidence

The medical evidence includes various recent chest x-rays, pulmonary function studies, arterial blood gases, and physicians' opinions, which were obtained after August 2, 1999, the date upon which the most recent prior claim was finally denied (DX 33-41).

A. Chest X-rays

The record contains multiple interpretations of recent chest x-rays, dated April 2, 2001 (DX 13, 14, 18), May 29, 2001 (DX 17, 19), and May 15, 2002 (EX 9, 15). The majority of the interpretations, including those by B-readers and/or Board-certified radiologists are negative for pneumoconiosis. Accordingly, Claimant has not established the presence of pneumoconiosis on the basis of the recent x-ray evidence.

B. Pulmonary Function Studies

A claimant must show he is totally disabled and that his total pulmonary disability is caused by pneumoconiosis. The regulations set forth criteria to be used to determine the existence of total disability which include the results of pulmonary function studies and arterial blood gas studies.

The record contains recent pulmonary function studies, dated April 2, 2001 (DX 10), May 29, 2001 (DX 17), May 10, 2002 (EX 19), and May 15, 2002 (EX 9). None of the studies (before or after bronchodilator) are qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix B. In view of the foregoing, the recent pulmonary function study evidence does not establish a totally disabling pulmonary or respiratory impairment.

C. Arterial Blood Gas Studies

Blood gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise.

The record includes recent arterial blood gas studies which were administered on April 2, 2001 (DX 12), May 29, 2001 (DX 17), May 10, 2002 (EX 19), and May 15, 2002 (EX 9). Upon review, the April 2, 2001 arterial blood gas studies at rest and exercise were found to be valid by Dr. Dominic J. Gaziano, a B-reader who is Board-certified in Internal Medicine, Chest Diseases, and Critical Care. Dr. Gaziano was noted by simply checking the "Yes" box on the U.S. Department of Labor validation form, thereby indicating that the test was "technically acceptable" (DX 12). Dr. Joseph J. Renn, III, a B-reader who is Board-certified in Internal Medicine and Pulmonary Disease, also reviewed the April 2, 2002 arterial blood gas studies. In his report, dated April 19, 2002, Dr. Renn stated, in pertinent part:

> The US DOL Report of Arterial Blood Gas Study reveals a resting oxygen tension (pO2) of 67 and an exercise pO2 of 61. The Cardiopulmonary Exercise Summary Report, however, provides an oxygen tension (paO2) of 85 at rest. Thusly, the arterial blood gas studies are inconsistent with that subsequently reported to the U.S. Department of Labor.[5]
>
> Additionally, the measurement of "wasted ventilation" is reported as being normal both at the anaerobic threshold and during peak exercise implying, from that aspect, that there should have been no interference with gas transfer.

(EX 18).

As noted, I find Dr. Renn's statement, which appears to question the validity of the April 2, 2002 arterial blood gases, to be based, at least in part, upon a false premise. Therefore, I accord Dr. Renn's comment little weight.

In summary, the record contains six sets of recent [resting and exercise] arterial blood gas studies. Of the foregoing, only the April 2, 2001 exercise study is qualifying under the regulatory standards set forth in 20 C.F.R. Part 718, Appendix C. In view of the progressive, irreversible, and latent nature of pneumoconiosis, I accord greater weight to the more recent studies, which are nonqualifying at rest and with exercise. Accordingly, I find that the recent arterial blood gas evidence does not establish a totally disabling pulmonary or respiratory impairment.

D. Physicians' Opinions

The case file includes the recent medical opinions of Drs. Rasmussen (DX 11; EX 7), Bellotte (DX 17; EX 8), and Zaldivar (EX 9, 23), which were submitted in conjunction with the current claim.

Dr. Donald L. Rasmussen, a B-reader who is Board-certified in Internal Medicine, has seen "probably 50,000" miners, and has an ongoing relationship with the U.S. Department of Labor, providing disability evaluations on its behalf. Although Dr. Rasmussen trained and completed a fellowship in pulmonary diseases, he never sat for the qualifying Board examination (EX 7, pp. 4-6). Dr. Rasmussen examined Claimant on April 2, 2001 (DX 11). On a U.S.

[5] Dr. Renn appears to have confused the "Baseline" PaO2 result of "85" with the value obtained at rest, which Dr. Rasmussen had reported as "67" (DX 12).

Department of Labor form, Dr. Rasmussen reported Claimant's last usual coal mine job of at least one year as shuttle car operator. He stated that the job entailed loading and unloading supplies, shoveling to clean up the tail piece, and, carrying 50 lb. rock dust bags a distance of 200 feet. In summary, Dr. Rasmussen concluded that the job entailed "considerable heavy manual labor." Prior thereto, Claimant reportedly worked in various coal mine jobs from 1957 to 1985 (DX 11, Sec. B). In addition, Dr. Rasmussen reported a negative cigarette smoking history; Claimant's family and medical histories, and subjective complaints of breathing problems and productive coughing. On physical examination, Dr. Rasmussen described the physical findings on percussion and auscultation of the thorax and lungs as normal, except for a thoracotomy scar. Furthermore, Dr. Rasmussen discussed various clinical test results, which were conducted on April 2, 2001, in the "Summary of Results" section of the form report, as follows:

Chest X-ray:	Pneumoconiosis s/p 1/0 all zones.
Vent Study (PFS)	Minimal obstructive ventilatory impairment.
Arterial Blood Gas	Marked impairment in oxygen transfer during exercise.
Other	SBDLCO moderately reduced.

(DX 11, Sec. D5).

Under the Cardiopulmonary Diagnoses and Etiology sections of the U.S. Department of Labor form report, Dr. Rasmussen reported that Claimant suffers from CWP and COPD/Emphysema attributable to coal mine dust exposure (DX 11, Secs. D6, 7). When asked the severity of Claimant's impairment from a chronic respiratory or pulmonary disease, if any, Dr. Rasmussen stated: "The patient has marked loss of lung function as reflected by the marked impairment in oxygen transfer during exercise. He does not retain the pulmonary capacity to perform his last regular coal mine job." (DX 11, Sec. D8b). Similarly, on a separate, typewritten report, dated May 2, 2001, Dr. Rasmussen reported that, the pulmonary function studies revealed only "minimal obstructive insufficiency" and the resting blood gases were "normal." However, the single breath carbon monoxide diffusing capacity was "moderately reduced" and the exercise blood gases showed "marked impairment in oxygen transfer and he was at least minimally hypoxic." Based upon the foregoing, Dr. Rasmussen stated:

> Overall, these studies indicate marked loss of lung function as reflected principally by the impairment in oxygen transfer during exercise. This degree of impairment would render this patient totally disabled for resuming his last regular coal mine job with its attendant requirement for heavy manual labor.
>
> The patient has a significant history of exposure to coal mine dust. He has x-ray changes consistent with pneumoconiosis. It is medically reasonable to conclude that he has coalworkers' [sic] pneumoconiosis which arose from his coal mine employment.

> The only known risk factor for this patient's totally disabling respiratory insufficiency is his coal mine dust exposure. The pattern of impairment in this case is also typical of many symptomatic coalworkers [sic], reinforcing the opinion concerning his coal mine origin of his disabling lung disease.

(DX 11).

In deposition testimony on January 8, 2002, Dr. Rasmussen acknowledged that the actual operation of the shuttle car entailed relatively light labor; but that the shoveling to clean at the tailpiece, unloading supplies, and carrying 50-pound rock dust bags 200 feet entailed heavy work. Thus, overall, Dr. Rasmussen stated that the job involved "intermittent heavy labor." (EX 7, pp. 11-12). In addition, Dr. Rasmussen acknowledged that, based upon the pulmonary function results, in particular the FEV1 value, Claimant "could do pretty much heavy work with that kind of FEV1…And that was confirmed during exercise since he did have adequate ventilatory reserve." (EX 7, pp. 21). Furthermore, Dr. Rasmussen testified that Claimant was "definitely overweight" [5' 8" height, 218 lbs]. While he conceded that Claimant's weight could contribute to shortness of breath, Dr. Rasmussen stated that he did not believe it would contribute to Claimant's impaired lung function (EX 7, pp. 17-18). In summary, Dr. Rasmussen specified that the basis for his finding that Claimant suffers from a pulmonary impairment was the blood gas studies during exercise, which revealed marked impairment at transfer and that Claimant was at least minimally hypoxic (EX 7, p. 32). Dr. Rasmussen also stated that Claimant "exercised at about 5.5 mets." In relationship to coal mine work, Dr. Rasmussen described the "range of mets" as follows:

> Well, the range of mets that might be required in a coal mine could actually go up quite a bit, perhaps as far as 8 mets for very heavy labor and, of course, it could be as low as - - for ordinary labor, as low as 3 ½ mets, so it varies, but with heavy work, you'd expect it to be 6 mets or above.

(EX 7, pp. 36-37).

Dr. John A. Bellotte is a B-reader, who is Board-certified in Internal Medicine and Pulmonary Medicine, and his practice is devoted almost exclusively to direct patient care, where he sees individuals who have worked in or around the coal mines on a daily basis. Furthermore, Dr. Bellotte has administered examinations for the Department of Labor for about 25 years (DX 17; EX 8, pp. 3-4). Dr. Bellotte examined Claimant on May 29, 2001. In a report, dated August 7, 2001, Dr. Bellotte described Claimant's background and coal mine employment history as follows:

> On a review of his coal mine employment, he worked at he [sic] Sewell Coal Company from 1970 to 1985. His jobs there included being a shuttle car operator, he ran a continuous miner and bolt machine. He also worked for Island Creek Coal Company from 1957 to 1970 as a shuttle car operator and general laborer. From 1985 he hauled gavel with a dump truck. He quit the coal mines back in 1985 because the mines shut down. At that time he was 50 years of age. He states he then waited for five years before

> retiring. His last job in the mines was that of a coal truck driver for six months, but prior to that he ran a continuous miner for five or six years. Dr. Rasmussen previously tested him in Beckley. He worked for a total of 31 years under ground with coal mine companies and he previously has received a ten percent state of WV black lung award. He was in the Marines for three years.

(DX 17). Dr. Bellotte also reported Claimant's family and individual histories; a negative smoking history; and, Claimant's subjective complaints of productive cough, wheezing, and shortness of breath on exertion. On physical examination, Dr. Bellotte reported, in pertinent part: some mild decrease in breath sounds and some rales at the right base; lungs are clear to auscultation. Clinical testing included a chest x-ray, pulmonary function studies, arterial blood gases, and electrocardiogram. Dr. Bellotte found 0/1 small opacities on chest x-ray, which was not sufficient perfusion to justify a diagnosis of simple pneumoconiosis. In addition, the "left chest showed some distorted anatomy and some rib fractures from the old motor vehicle accident." Spirometry was "within normal limits," and no significant response after bronchodilator. There was a "mild impairment" of the diffusion capacity. Resting arterial blood gas indicated a "mild impairment of pulmonary gas exchange." The exercise arterial blood gas "indicated normal pulmonary gas exchange at the peak of exercise and shows an improvement in the PO2 with the exercise, which is a normal physiologic response." The resting and exercise electrocardiogram results showed no significant abnormalities (DX 17). Based upon the foregoing, Dr. Bellotte stated, in pertinent part:

> It is my impression, and I can state with a reasonable degree of medical certainty, that there is insufficient objective evidence to justify a diagnosis of coal workers pneumoconiosis with respect to this man.
>
> He has mild pulmonary respiratory impairment, but this impairment is not attributed to pneumoconiosis. His impairment is due to some mild chronic obstructive pulmonary disease with chronic bronchitis based on history of cough and sputum production. The borderline restriction we see on his pulmonary function testing is attributed to his previous motor vehicle accident with trauma to his chest wall resulting in some residual loss of ventilatory capacity. He previously had a pneumothorax on his left side and required chest tubes. Of course the motor vehicle accident and the resultant rib fractures and treatment are not related to coal dust exposure from his coal mine employment. He is not totally and permanently disabled. He retains the ventilatory capacity to perform his last regular coal mining job or work requiring similar effort. He was able to achieve 6.3 METS on the exercise testing, which is well above the oxygen requirements to do his last coal mining duties. He does have some other medical problems that might preclude his employment and these problems include his arthritis, cancer of the prostate, his hypertension that is currently being treated and his problems with sinusitis and tinnitus and dizziness. None of these problems are in any way related to his coal dust exposure and his coal mine employment history.

(DX 17).

Dr. Bellotte also testified at deposition held on May 10, 2002 (EX 8). Prior thereto, Dr. Bellotte reviewed various medical records, including Dr. Rasmussen's medical report (EX 8, p. 4). Dr. Bellotte reiterated that the chest x-ray evidence did not establish coal worker's pneumoconiosis; that the pulmonary function studies are "on the borderline range for some mild restriction," which he thought was related to obesity and scarring from the old motor vehicle accident noted on chest x-ray. Furthermore, Dr. Bellotte found no evidence of obstructive impairment. In addition, Dr. Bellotte found that the arterial blood gases at rest were mildly low, but the exercise blood gases showed fairly good exercise. Moreover, Dr. Bellotte stated that Claimant was able to increase his mets to 6.3 during exertion. Therefore, "using the AMA Guidelines, the Fifth Edition, would indicate that that he would be able to do heavy work." (EX 8, pp. 11-15). Furthermore, Dr. Bellotte stated that Dr. Rasmussen's exercise study results were actually "a little bit higher" than 5.5 mets. In making this determination, Dr. Bellotte stated:

> Well, because Dr. Rasmussen indicates that on his oxygen consumptions that he actually consumes 1.37 liters per minute during the first level of exercise, 1.9 liters per minute at peak exercise. And from those he calculates that his peak consumption will be 2.4 liters. And I already explained to you that one liter would be four mets, and two liters would be eight mets. And so Dr. Rasmussen is calculating that this gentleman would be able to do over eight mets of work…Had he gone to the peak amount of work that he would do.

(EX 8, pp. 15-16).

Accordingly, Dr. Bellotte disagreed with Dr. Rasmussen's conclusion that Claimant has severe impairment in lung function. To the contrary, Dr. Bellotte stated: "Because if we go by the guidelines, how can you have severe impairment if you're able to do arduous work? And that's what Dr. Rasmussen has calculated that Mr. Cutright's able to do." (EX 8, p. 16). Finally, based on the coal mine employment history provided him, Dr. Bellotte added that Claimant could perform his last coal mine employment as a coal truck driver or continuous miner operator (EX 8, p. 17).

Dr. George L. Zaldivar is a B-reader, who is Board-certified in Pulmonary Disease, Internal Medicine, Sleep Disorder, and Critical Care Medicine (EX 9). Dr. Zaldivar examined Claimant on May 15, 2002. In a "History & Physical Examination" report, dated May 15, 2002, Dr. Zaldivar set forth Claimant's chief complaint of shortness of breath; history of present illness; past medical history; personal and social history; family and personal illnesses; and, review of systems. In addition, Dr. Zaldivar described Claimant's work history as follows:

> He agrees with what he told me the last time. He worked in the mines for the last time in 1985 after working for 30 years and receiving credit for 28 ½ years. The mine closed down in 1985. For the last year, he was a shuttle car operator. He had to hang cable in the crossings. Other than that, he also had to load and unload supplies. Before then, for 7 years, he was a miner operator. He had a helper. When the equipment was down, he was called on to do general labor work about once a month. In the mines he operated all of the equipment. He was a pumper. The pump was heavy and had to be handled by 2 people. Before he was in the mines, he was in the Marine Corps for 3 years in the infantry.

(EX 9). Dr. Zaldivar also set forth his findings on physical examination. In pertinent part, Dr. Zaldivar stated: "Lungs are clear to auscultation without wheezes, crackles, or rales. He has a well-healed surgical scar, which is extensive, from the medical portion of the scapula to the left anterior left auxiliary line." (EX 9). In summary, Dr. Zaldivar stated:

IMPRESSION:

1. History of extensive surgery of the left lung after trauma to it, which resulted in bleeding and subsequent surgery.
2. Normal examination of the lungs.

(EX 9).

In a supplemental report, dated June 4, 2002 (EX 9), Dr. Zaldivar reviewed and analyzed his own examination, including laboratory data which he obtained, in conjunction with a review of other available medical evidence. In summary, Dr. Zaldivar stated:

FINDINGS

My own findings are as follows:

1. Summary of the History and Physical examination as listed under "Impression."
2. No radiographic evidence of pneumoconiosis. There is radiographic evidence of trauma to the left lung.
3. Normal spirometry.
4. Mild restriction of Total Lung Capacity.
5. Mild diffusion impairment with normal DL/VA.
6. Worsening of ventilation and perfusion match during exercise at 14.88 cc/kg/minute with mild hypoxemia occurring during exercise.

OPINIONS

Based on all this information, my answers to your questions are as follows:

1. There is no evidence in this case to justify a diagnosis of coal worker's pneumoconiosis nor any dust disease of the lungs.

2. There is a pulmonary impairment present. The impairment is the result of a previous injury to his left lung which was quite severe. There is limitation to exercise which would prevent Mr. Cutright from performing his usual coal mining work which requires heavy manual labor. This pulmonary impairment is the result of the chest trauma which occurred during the car accident.

3. The impairment which he has is a restrictive impairment which has been present over the years. The diffusion impairment has also been present over the years. It

is this diffusion impairment combined with ventilation and perfusion mismatch during exercise which is responsible for the hypoxemia.

4. Even if Mr. Cutright were found to have early simple pneumoconiosis, pneumoconiosis would have no contribution at all in the restrictive impairment which he has nor in the ventilation and perfusion mismatch which he also has, as well as the diffusion impairment, all of which are the result of the car accident. Even if he had coal worker's pneumoconiosis, my opinion regarding Mr. Cutright would remain the same as I have given here.

(EX 9).

Dr. Zaldivar also testified at deposition held on November 26, 2002 (EX 23). Following Dr. Zaldivar's further discussion of the medical evidence, including his own findings, as well as those of Drs. Rasmussen and Bellotte, Dr. Zaldivar stated that the tests overall indicate that Claimant has a mild pulmonary impairment, as shown on diffusion capacity and blood gases (EX 23, pp. 4-28). Unlike his written report, where Dr. Zaldivar explicitly stated that Claimant's impairment "would prevent Mr. Cutright from performing his usual coal mining work which requires heavy manual labor (EX 9)," Dr. Zaldivar's testimony at deposition was somewhat ambiguous and equivocal. When asked explicitly whether Claimant's pulmonary impairment is totally disabling, Dr. Zaldivar stated, in pertinent part:

> Well, it wouldn't normally be, but he's getting older. He's sixty-seven now. I have examined him before, and before he [was] not disabled with pulmonary impairment at all. But as he gets older, the lungs get older as well and are less efficient.
> So for very heavy labor, if he were to lift seventy-five pounds and carry it about and things like that on a continuous basis, I would expect that he would be the [sic] disabled for that kind of work. He would be very, very short of breath. Now, he'd be able to do it, but he'd be very short of breath.
> And the reason I am saying what I just said about his lungs getting older is that I have a blood gas test here taken back to, well 5/13, 1999, when I exercised him on the bicycle at that time.
> And the pO2 actually improved. It was ninety-two at rest and eighty-nine with exercise. Well, it didn't improve. There was still a drop in the pO2 from ninety-two to eighty-nine, but eighty-nine is a wonderful pO2 for anyone.
> So for very heavy manual labor, he is. From at work, he's not. For sedentary work and light work, he is not.

(EX 23, pp. 28-29). In response to further questioning regarding whether Claimant is totally disabled based upon the Claimant's description of his coal mine work, Dr. Zaldivar stated, in pertinent part:

> Well, his last work, according to him, was in 1985 after thirty years. He was a shuttle car operator. He had to hang the cable and the crossings. That's not - - I mean, that's strenuous when you're doing it, but it is a short-lived exercise, but he is able to do it.

> Now, loading and unloading supplies is the part that I wasn't too sure of, depending on the length of time that is spent loading and unloading and the weight of the supplies and how you carry them. That job may be difficult for him to do.
> If you are dealing with large headers weighing over a hundred pounds and you need two people to carry it, that might be a little bit difficult. But the rest of the job, he can do. He can be a shuttle car operator with no problem. He can hang cable with no problem. He can do some shoveling with no problem.

(EX 23, pp. 29-30).

Although Dr. Zaldivar's testimony is somewhat ambiguous and equivocal regarding the total disability issue, he clearly and unequivocally testified that Claimant's mild restrictive pulmonary impairment is the result of his previous injury, and is wholly unrelated to Claimant's coal dust exposure. Furthermore, Dr. Zaldivar reiterated that, based upon Claimant's history, physical examination, breathing tests, blood gases, and chest x-ray, Claimant does not have pneumoconiosis, or any coal mine-related impairment (EX 23, pp. 30-32).

Pneumoconiosis

Section 718.202 provides four means by which pneumoconiosis may be established. Under §718.202(a)(1), a finding of pneumoconiosis may be made on the basis of the x-ray evidence. As stated above, the majority of the interpretations of the recent chest x-rays, including those by B-readers and/or Board-certified radiologists, are negative for pneumoconiosis. Accordingly, Claimant has not established the presence of pneumoconiosis on the basis of the recent x-ray evidence under §718.202(a)(1).

Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found applicable. In the instant case, the presumption of §718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is inapplicable to claims filed after January 1, 1982. Finally, the presumption of §718.306 does not apply to living miner's claims. Therefore, the Claimant cannot establish pneumoconiosis under §718.202(a)(3).

Under §718.202(a)(4), a determination of the existence of pneumoconiosis may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in §718.201. Pneumoconiosis is defined in §718.201 means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both "Clinical Pneumoconiosis" and "Legal Pneumoconiosis." *See* 20 C.F.R. §718.202(a)(1) and (2).

As stated above, the medical opinions filed in conjunction with the current claim include the recent reports and depositions of Drs. Rasmussen (DX 11; EX 7), Bellotte (DX 17; EX 8), and Zaldivar (EX 9,23). Of the foregoing, only Dr. Rasmussen diagnosed pneumoconiosis, both clinical and legal. In making this determination, Dr. Rasmussen relied, in part, upon a questionable positive x-ray evidence for pneumoconiosis, in conjunction with Claimant's extensive coal mine employment history. Furthermore, he noted no other risk factor for

Claimant's disabling insufficiency, except coal mine dust exposure. On the other hand, Drs. Bellotte and Zaldivar relied, in part, upon negative chest x-ray interpretations and cited Claimant's past history in which he was involved in a very serious motor vehicle accident, which damaged his lungs. Moreover, they attributed Claimant's pulmonary impairment to the lung damage caused in the accident. Although Dr. Rasmussen is Board-certified in Internal Medicine and has extensive experience examining coal miners, he lacks the Board-certification in Pulmonary Diseases, which Drs. Bellotte and Zaldivar possess. Furthermore, Dr. Rasmussen's analysis was more limited, since it focused almost entirely on his own clinical findings. In contrast, Drs. Bellotte and Zaldivar not only considered their own findings, but also analyzed those of other physicians, including Dr. Rasmussen. Finally, I note that, while the examinations conducted by Drs. Rasmussen and Bellotte, in 2001, were almost contemporaneous, Dr. Zaldivar had the benefit of administering the most recent examination, in May 2002 (*i.e.,* approximately one year later). In view of the foregoing, I accord greater weight to the opinions of Drs. Zaldivar and Bellotte over that of Dr. Rasmussen. Therefore, I find that Claimant has failed to establish the presence of pneumoconiosis under §718.202(a)(4), or by any other means.

I have also weighed all the relevant evidence, submitted in conjunction with the current claim, together under 20 C.F.R. §718.202(a) to determine whether the miner suffered from pneumoconiosis. Since the weight of both the recent x-ray evidence and medical opinion evidence does not establish pneumoconiosis, I find that pneumoconiosis has not been established under 20 C.F.R. §718.202(a). *See, Island Creek Coal Co. v. Compton*, 211 F. 3d 203, 2000 WL 524798 (4th Cir. 2000); *Penn Allegheny Coal Co. v. Williams,* 114 F. 3d 22 (3d Cir. 1997).

Even if simple pneumoconiosis were found based on the recent medical evidence, it would not meet the threshold standard which the Claimant must meet before his claim may be reviewed *de novo*. In so finding, I note that, in the most recent final denial of the prior claim, the District Director found that Claimant had established the presence of pneumoconiosis (DX 33-41, p. 3). Therefore, a finding of pneumoconiosis would not represent a change in the miner's physical condition within the meaning of 20 C.F.R. §725.309(d)(2),(3), as amended.

Causal Relationship

Since Claimant has failed to establish the presence of (clinical or legal) pneumoconiosis, he clearly cannot establish that the disease arose from his coal mine employment. Furthermore, even if Claimant had established that he had pneumoconiosis arising from his coal mine employment, it also would not represent a change in the miner's physical condition under 20 C.F.R. §725.309(d)(2),(3), as amended. In the final denial of the prior claim, the District Director found that Claimant had established such a causal relationship. (DX 33-41, p. 4).

Total Disability

The regulations provide that a claimant can establish total disability by showing the miner has a pulmonary or respiratory impairment which, standing alone, prevents the miner from performing his or her usual coal mine work, and from engaging in gainful employment in the immediate area of his or her residence requiring the skills or abilities comparable to those of any employment in a mine or mines in which he or she previously engaged with some regularity over

a substantial period of time. *See* 20 C.F.R. §718.204(b)(1). Where, as here, complicated pneumoconiosis is not established, total disability may be established by pulmonary function tests, by arterial blood gas tests, by evidence of cor pulmonale with right-sided congestive heart failure, or by physicians' reasoned medical opinions, based upon medically acceptable clinical and laboratory diagnostic techniques, that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in his usual coal mine work or comparable employment. *See* 20 C.F.R. §718.204(b)(2)(i)-(iv).

As outlined above, the record does not contain any recent, valid, qualifying pulmonary function studies under the applicable regulatory criteria set forth in Part 718, Appendix B. To the contrary, the recent pulmonary function results reveal minimal, if any, respiratory or pulmonary impairment. Therefore, Claimant has clearly not established total disability pursuant to §718.204(b)(2)(i).

Of the recent arterial blood gas studies, which were submitted in conjunction with the current claim, five of the six [resting and exercise] tests were nonqualifying under the applicable standards stated in Part 718, Appendix C. Only the exercise blood gas study, administered by Dr. Rasmussen on April 2, 2001, yielded qualifying values. Since the vast majority of the blood gas studies, including the more recent exercise blood gas studies, are not qualifying, I find that Claimant has not established total disability pursuant to §718.204(b)(2)(ii).

Since there is no evidence which establishes the presence of cor pulmonale with right-sided heart failure, Claimant has also failed to establish total disability pursuant §718.204(b)(2)(iii).

Finally, I have carefully reviewed the recent medical opinion evidence in order to ascertain whether such evidence establishes the presence of a total (pulmonary or respiratory) disability. As outlined above, the nature of Claimant's last usual coal mine job is set forth in Claimant's testimony at the formal hearing (TR 15-18), in the "Description of Coal Mine Work and Other Employment" form (DX 3), and, in the medical reports of Drs. Rasmussen, Bellotte, and Zaldivar. Taken as a whole, the evidence establishes that Claimant's last usual coal mine job was as a heavy equipment operator. Although Claimant operated various heavy equipment operator, it primarily entailed operating a shuttle car. The actual operation of the shuttle car constituted relatively light work. However, within the collective job descriptions, various other aspects of Claimant's work were cited, such as hanging cable, rock dusting, setting timbers, shoveling, and/or loading and unloading supplies, which I find entailed periodic, moderately heavy manual work. Citing the abnormal exercise blood gas which he obtained, Dr. Rasmussen opined that Claimant's pulmonary impairment would prevent him from performing his last coal mine job, with its requirement for heavy manual labor. In contrast, Dr. Bellotte cited the clinical test results, including the results of the exercise blood gas studies, and found that under the AMA Guidelines, Claimant would be able to do heavy work. Accordingly, even though Dr. Bellotte may have misidentified Claimant's last usual coal mine job as a "coal truck driver" or "continuous miner operator," his overall opinion was that Clamant could perform heavy work. Since Claimant's last usual coal mine job entailed only periodic, moderately heavy work, I find that Dr. Bellotte's opinion, if credited, would establish that Claimant does not suffer from a totally pulmonary or respiratory disability. Finally, as discussed above, Dr. Zaldivar provided a

somewhat conflicting, ambiguous, and equivocal analysis regarding the total disability issue. In his report, dated June 4, 2002, Dr. Zaldivar clearly stated that Claimant's limitation to exercise would prevent him from performing his usual coal mine work which required heavy manual labor. However, in his deposition testimony, Dr. Zaldivar indicated that Claimant could do the vast majority of the duties required in his last coal mine job, while conceding he may have difficulty with some aspects of the job.

Having carefully considered the foregoing medical opinion evidence, I find that, taken as a whole, such evidence neither precludes nor establishes total disability as defined in §718.204(b)(1). Accordingly, Claimant has not met his burden of establishing total disability under §718.204(b)(2)(iv), or by any other means.

Even if Claimant had established the presence of a totally disabling pulmonary or respiratory impairment, it would still not meet the threshold standard which the Claimant must meet before his claim may be reviewed *de novo*. In so finding, I note that, in the most recent final denial of the prior claim, the District Director stated that the parties agreed that total disability had been established (DX 33-41, p. 4).

Total Disability Due to Pneumoconiosis

Since I find that Claimant has failed to establish either the presence of pneumoconiosis and/or that he suffers from a total (pulmonary or respiratory) disability based upon the recent medical evidence, he clearly cannot establish total disability due to pneumoconiosis. 20 C.F.R. §718.204(c). Moreover, for the reasons outlined above, I credit the opinions of Drs. Zaldivar and Bellotte over that of Dr. Rasmussen. Therefore, I find that Claimant's pulmonary or respiratory impairment is unrelated to pneumoconiosis and/or Claimant's coal mine dust exposure.

Conclusion

The new evidence submitted in conjunction with the current claim failed to establish *disability causation*, which was the only applicable condition of entitlement upon which the prior denial was based. *See* 20 C.F.R. §725.309(d)(2),(3). Moreover, the recent evidence undermines the District Director's prior findings of pneumoconiosis and causal relationship; and, such evidence is inconclusive regarding the total disability issue. In view of the foregoing, Claimant is not eligible for benefits under the Act and regulations.

ORDER

It is ordered that the claim of John W. Cutright for benefits under the Black Lung Benefits Act is hereby **DENIED.**

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RICHARD A. MORGAN
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision and Order, by filing a notice of appeal with the ***Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601.*** A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits, Frances Perkins Building, Room B2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.